Filed 7/13/20 Futterman v. Kaiser Foundation etc. CA1/4

NOT TO BE PUBLISHED IN OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT

DIVISION FOUR

SUSAN FUTTERMAN et al., Plaintiffs and Appellants, v. KAISER FOUNDATION HEALTH PLAN, INC., Defendant and Respondent.	A155946 (Alameda County Super. Ct. No. RG13697775)

Plaintiffs Susan Futterman, Maria Spivey and Acianita Lucero appeal the denial of class certification in their action against Kaiser Foundation Health Plan, Inc. (the Plan). Their operative fourth amended complaint seeks injunctive relief under the Unfair Competition Law (UCL) (Bus. & Prof. Code, § 17200), claiming that the Plan violates the California Mental Health Parity Act (Parity Act) (Health & Saf. Code, § 1374.72) by failing to provide coverage for all medically necessary treatment of severe mental illness, and statutory penalties under the Unruh Act (Civ. Code, § 51), claiming that Kaiser intentionally discriminates against persons with disabilities by treating members with mental disabilities differently than members with physical disabilities.[1]

[1] In a consolidated action, *Dion v. Kaiser Foundation Health Plan, Inc.*, Alameda County Superior Court No. RG14718903, the trial court certified a class "to prosecute a claim . . . that the Kaiser Plan is engaged in an unlawful business practice in violation of [the Health and Safety Code] because it has failed to establish uniform guidelines for residential treatment that are consistent with the standard of care." Plaintiffs unopposed request for judicial notice of the order approving the class action settlement and the final judgment in the *Dion* case is granted.

The trial court denied plaintiffs' motion for class certification on the grounds that plaintiffs failed to demonstrate that common issues of law and fact predominate and that class treatment is not the superior means of resolving plaintiffs' claims. In denying plaintiffs' motion, the court relied heavily on the authority of the Department of Managed Health Care (DMHC) to supervise the Plan's provision of mental health care treatment and to resolve plaintiffs' claims. At our request, the DMHC submitted an amicus brief addressing its role with respect to plaintiffs' claims. As the DMHC's brief demonstrates, the trial court's reliance on the DMHC to police the violations of the Parity Act that plaintiffs allege was not justified. In part because of that reliance and in part because of a misconception of plaintiffs' claims, the court's finding that common issues going to the merits of the UCL cause of action do not predominate must be re-examined. We find no abuse of discretion, however, with respect to the denial of the proposed Unruh Act subclass. Accordingly, we shall reverse the order denying class certification and remand the matter so that the trial court can determine whether plaintiffs' UCL claims, properly construed, are appropriate for class certification.

Background

The Plan is a nonprofit health care service plan subject to the Knox-Keene Health Care Service Plan Act of 1975 (Health & Saf. Code, § 1340 et seq.), of which the Parity Act is a part. The Plan is part of the integrated Kaiser Permanente health care delivery system and provides coverage through exclusive contracts with medical providers, including The Permanente Medical Group (TPMG) in Northern California and Permanente Medical Group in Southern California (SCPMG).

The Parity Act provides, in relevant part: "Every health care service plan contract . . . that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of severe mental illness of a person of any age, and of serious emotional disturbances of a child . . . under the same terms and conditions applied to other medical conditions . . . ." (Health & Saf. Code, § 1374.72, subd. (a); see also *Rea v. Blue Shield of California* (2014) 226 Cal.App.4th 1209, 1238 [The Parity Act requires "treatment of mental illnesses sufficient to reach the same

quality of care afforded physical illnesses."].) Subdivision (d) of section 1374.72 defines severe mental illnesses to include a list of recognized disorders, including schizophrenia, bipolar disorder, major depressive disorders, panic disorder, anorexia nervosa, and bulimia nervosa.

Plaintiffs' fourth amended complaint alleges, among other things, that the Plan violates the Parity Act by "[d]enying, dissuading and deterring members from obtaining one-on-one mental health therapy without making individualized determinations as to the medical necessity of one-on-one mental health therapy for individual members, and where similar policies and practices are not followed in the treatment of physical health conditions; [r]equiring, recommending, and/or encouraging 'group' therapy, without making individualized determinations as to the medical necessity or suitability of group therapy" and "without making individualized determinations as to the type of group therapy appropriate and medically necessary for individual members, and where similar policies and practices are not followed in the treatment of physical health conditions;" and "[a]ssigning members in need of mental health treatment to one-size-fits-all group-based [intensive outpatient programs] or similar programs, without making individualized medical determinations as to whether it is medically necessary or appropriate for the member, without tailoring the program to the member's individual medical need . . . where similar policies and practices are not followed in the treatment of physical health conditions." Plaintiffs' cause of action under the Unruh Act alleges that Kaiser intentionally discriminates against persons with mental disabilities or conditions by treating them differently from people with physical disabilities or conditions.

The amended complaint describes at length the experiences of the three plaintiffs or their dependents illustrating these alleged deficiencies. In short, the deceased husband of plaintiff Susan Futterman, who had been "diagnosed as having bipolar disorder" and who ultimately committed suicide, was released following a 72-hour stay in an inpatient facility into a group-based intensive outpatient program. The complaint alleges, "No one individually assessed [him] for his suitability in the program, or the medical necessity of the program. The . . . program consisted of group therapy sessions four times per week

for the next six weeks and intermittent medication management. [He] was never offered individual psychotherapy as a treatment option. The group-based [intensive outpatient program] . . . is a one-size-fits-all program that is not tailored to the individual medical needs of particular patient or diagnosis." The program "consisted of a very large group of individuals, many of whom were recovering from substance abuse. [Futterman's husband] felt that he could not relate to the problems of these individuals who did not share his condition." When Futterman told Kaiser that she did not believe her husband was well-suited for group therapy, Kaiser told her that "was what was available."

Plaintiff Acianta Lucero, who had been "diagnosed as having major depression," was also "automatically placed in group therapy and put into the group-based [intensive outpatient program] without any discussion about the possibility of one-on-one therapy as an alternative. There also was no assessment as to the suitability of group therapy or the type of group therapy that should be provided." During the course of her treatment, Lucero received "educational materials" from Kaiser that read, " 'We offer brief, problem solution-focused individual counseling . . . . We do not offer long-term individual psychotherapy at Kaiser.' " Her experience assertedly "is not uncommon for Kaiser members seeking mental health treatment" but "[s]imilar policies and practices are not followed in Kaiser's treatment of physical health conditions."

Plaintiff Maria Spivey's deceased minor daughter, who had been "diagnosed as having major depression, anxiety, and post traumatic stress disorder," and who ultimately committed suicide, was "automatically referred . . . into [Kaiser's] group-based 'aftercare' program" following her completion of six weeks of inpatient treatment without "any kind of individual assessment" of her condition. Her experiences assertedly "are illustrative of Kaiser's one-size-fits-all approach to mental health treatment that violates the Parity Act and Unruh Act. [She] was not individually assessed to determine whether the Aftercare program was medically necessary or an appropriate means to treat her mental health condition. Rather, she was automatically put into a group-based program upon release from the inpatient facility. At no point after her release from the inpatient program was [she] offered individual one-on-one counseling or assessed to

determine whether one-on-one counseling was medically necessary or would have been a more appropriate way to treat her condition. The only individualized meetings that she had were for medication management."

Plaintiffs' motion to certify a "Parity Act class" described the requested class as follows: "All California residents who were members of Kaiser Foundation Health Plan, Inc. and who, at any time within four years of the filing of the complaint to the mailing of the class notice of this action, was diagnosed, or whose covered dependents were diagnosed, with a severe mental illness or severe emotional disturbance of a child, as defined in the California Mental Health Parity Act [and whose treatment at Kaiser was limited by availability of treatment modality, regardless of medical necessity]. Excluded from this definition are members whose terms are governed under federal plans, such as ERISA [Employee Retirement Income Security Act], and Medi-Cal plans." The bracketed clause was not included as plaintiffs' primary request but was included as an alternate request. Plaintiffs' motion also requested certification of an "Unruh Act subclass" defined to include those Kaiser members so diagnosed "who have had a 'mental disability' or mental health 'medical condition' as defined in sections 12926 and 12926.1 of the California Government Code."

After considering the evidence and arguments submitted in support of and opposition to the motion for class certification, the trial court entered an order denying the motion. The court found that the numerosity, ascertainability, typicality[2] and adequacy of representation[3] requirements were satisfied but that common issues of law

[2] The court found that the claims of Lucero and Spivey are typical of the claims of other class members but that Futterman is not a typical plaintiff because she is not a member of the Kaiser plan and receives medical coverage under an insurance policy issued by Kaiser Permanente Insurance Company, which is not a party to the action. We agree; in the event that a class ultimately is certified, Futterman should not be a class representative.

[3] The court expressed "serious concerns" about whether the law firm representing plaintiffs, although competent, could adequately represent the proposed class because of its concurrent representation of the union for mental health providers who work for

and fact did not predominate and that alternate procedures for resolving the dispute were superior to class treatment. Plaintiffs timely appealed from the denial of their motion for class certification.

Discussion

"Originally creatures of equity, class actions have been statutorily embraced by the Legislature whenever 'the question [in a case] is one of a common or general interest, of many persons, or when the parties are numerous, and it is impracticable to bring them all before the court. . . .' [Citations.] Drawing on the language of Code of Civil Procedure section 382 and federal precedent, we have articulated clear requirements for the certification of a class. The party advocating class treatment must demonstrate the existence of an ascertainable and sufficiently numerous class, a well-defined community of interest, and substantial benefits from certification that render proceeding as a class superior to the alternatives. [Citations.] 'In turn, the "community of interest requirement embodies three factors: (1) predominant common questions of law or fact; (2) class representatives with claims or defenses typical of the class; and (3) class representatives who can adequately represent the class." ' " (*Brinker Restaurant Corp. v. Superior Court* (2012) 53 Cal.4th 1004, 1021.)

Our review of the trial court's decision "is narrowly circumscribed. 'The decision to certify a class rests squarely within the discretion of the trial court, and we afford that decision great deference on appeal, reversing only for a manifest abuse of discretion: "Because trial courts are ideally situated to evaluate the efficiencies and practicalities of permitting group action, they are afforded great discretion in granting or denying certification." [Citation.] A certification order generally will not be disturbed unless (1) it is unsupported by substantial evidence, (2) it rests on improper criteria, or (3) it rests on erroneous legal assumptions.' " (*Brinker Restaurant Corp. v. Superior Court*, *supra*, 53 Cal.4th at p. 1022.)

TPMG and SCPMG. The court stated it "has concerns, but does not deny the Futterman motion for class certification based on the adequacy of [the firm] as counsel."

1. Parity Act Class

a. Plaintiffs' UCL Claim

It is undisputed that the Plan's formal policy purports to provide coverage for mental health services on the same basis as it provides coverage for physical health conditions: Behavioral health treatment is covered "for whatever length of time and at the frequency deemed medically appropriate by the practitioner." Plaintiffs allege, however, that despite the Plan's formal coverage policy, in practice it arranges for the delivery of treatment in a manner that results in the denial or limitation of coverage without a determination of medical necessity. Plaintiffs allege that because the Plan is part of an integrated system, it is responsible for the staffing, scheduling and other practices imposed on the practitioners that limit patients' access to individual therapy. Specifically, the complaint alleges "Kaiser regularly makes what constitute coverage, administration, and treatment decisions based on appointment availability rather than an individual assessment of a patient's medical needs, resulting in Kaiser members being denied or delayed one-on-one mental health therapy and being pushed into mental health group therapy and 'classes' without consideration of medical necessity and without regard as to whether individual or group therapy would be more medically effective or appropriate for the individual's condition. [¶] Kaiser has developed one-size-fits-all Intensive Outpatient Programs and/or Aftercare Programs that push patients suffering from acute mental health needs, without an assessment of individual medical necessity or appropriateness, into large groups and classes without regard to whether groups or classes are appropriate for the individual patient and without regard as to whether the type of groups or classes are appropriate. [¶] Kaiser does not provide adequate back-up coverage for mental health clinicians whose schedules are full or who are out of the office, resulting in added delay in accessing mental health services. By contrast, Kaiser members suffering from physical health conditions, such as the flu, can obtain prompt appointments with a medical provider even when their own medical provider is occupied or out of the office on vacation."

In overruling the Plan's demurrer to the Parity Act causes of action, the trial court concluded that the allegations of the complaint were sufficient to state a cause of action. As relevant here, the court concluded that the Plan's distinction between "coverage" and "treatment" and its argument that it could not be held to account for the "treatment" duties of its contracted medical providers was unfounded. The court explained that the allegation of an "integrated healthcare coverage, administration and delivery system" would suffice for pleading purposes. The court also rejected the Plan's argument that to state a cause of action for violation of the Parity Act plaintiffs must allege that the treatments that were not provided to them were "medically necessary." The court explained that while the complaint does not allege that individual therapy is "categorically" denied coverage, the allegations that their treatment and the treatment of purported class members "were not based on a proper determination of medical necessity" is sufficient for pleading purposes.

In denying certification, the trial court recognized that "In many class action lawsuits, a central issue is whether a defendant with a formal policy of doing 'X' has a consistent actual practice of doing 'Y'. Class certification can be appropriate in that context to address the alleged consistent actual practice." The court cited *Duran v. U.S. Bank National Assn*. (2014) 59 Cal.4th 1, 30, in which the court recognized that wage and hour laws could be violated by either an employer's "uniform policy" or its "consistent practice" and *Alberts v. Aurora Behavioral Health Care* (2015) 241 Cal.App.4th 388, 406, in which the court held that "the mere existence of a lawful . . . policy will not defeat class certification in the face of actual contravening policies and practices that, as a practical matter, undermine the written policy." The court recognized that while "the Kaiser Plan has a formal policy of covering mental health services[,] plaintiffs assert that TPMG and SCPMG, as agents of the Kaiser plan, had an actual consistent practice of not covering [Parity Act] required services."

b. The Authority of the DMHC

Plaintiffs' complaint alleges that in late 2011 or early 2012, the DMHC began conducting an investigation regarding the Plan's compliance with regulations

promulgated under the Knox-Keene Act. "After a lengthy investigation, the DMHC came out with its final report in or around March 2013. The DMHC's March 2013 report concluded that [the Plan] violated the law by, among other things, failing to properly monitor the capacity and availability of its network to ensure that members are offered appointments within the timely access rules' specifications, failing to take action to correct problems with its policies and systems, and by providing inaccurate, misleading, and/or confusing information to its members regarding the availability of its mental health services." Plaintiffs' complaint originally alleged a UCL cause of action, separate from the cause of action based on the alleged violation of the Parity Act discussed here, that was based on the Plan's alleged violation of the regulation promulgated under the Knox-Keene Act regarding timely access to non-emergency health care services. (Cal. Code of Regs., title 28, § 1300.67.2.2.) Through several rounds of demurrers after which the demurrer to that cause of action was sustained, the court found that "direct enforcement of the timely access regulation raises the very real specter of crossing the line between matters appropriate for judicial determination and those best left to the DMHC" and that the court would "defer to the DMHC on all issues having to do with whether Kaiser's [quality assurance] program is sufficient."

In denying certification, the court addressed the effect of Kaiser's subsequent settlement with the DMHC on plaintiffs' remaining UCL causes of action. The court's order states: "In July 2017, approximately four years after Futterman filed the complaint, the Kaiser Plan entered into a settlement agreement with the DMHC in which the Kaiser Plan agreed to make changes to its [quality assurance] program and to oversight by a DMHC approved consultant." The court explained that "the DMHC is charged with monitoring whether the Kaiser Plan's actual practice is to deliver the treatment and care required by the [Parity Act]" and that plaintiffs' claims "regarding one-on-one therapy are subject to DMHC oversight." We find scant evidence in the record that the DMHC in fact performs the broad oversight that the court assumed and, after soliciting the view of the DMHC, we are confident that the court's reliance on the agency's role and on the scope of the settlement agreement was mistaken.

The settlement agreement requires the Plan to work with a Behavioral Healthcare Consultant to address specified "corrective action area items" and to accomplish enumerated "deliverables." The agreement identifies six corrective action areas designed "to aid the Plan's Behavioral Health Quality Assurance program in ensuring that effective action is taken to improve care where deficiencies are identified in service areas, including accessibility, availability, and continuity of care." Of the six corrective action areas identified in the agreement, the Plan contends that only corrective action area number four overlaps with plaintiffs' claims. Corrective action area number four requires a "[f]ully implemented systematic process to monitor follow-up appointment access adherence to member's treatment plan" and provides that the Plan "must provide a clearly defined and fully implemented policy and process to be uniformly applied across both regions and all sites ensuring that follow-up appointments are offered consistent with the treating professional's clinical determination."[4] The agreement enumerates 11

[4] The additional corrective action area items are: "a. Improved documentation of the Plan's quality improvement efforts for access compliance. The Plan will develop a comprehensive Behavioral Health Quality Assurance . . . document that includes the Plan's behavioral health access compliance quality improvement efforts and all processes related to ensuring compliance with access standards including documenting roles, resources, responsibilities, activities, timelines, and functions of the health plan, and associated activities delegated to regional medical groups. (Herein 'Corrective Action Area No. 1'). [¶] b. Improved transparency in behavioral health appointment access compliance measurement. The Plan will develop a measurement mechanism or other means that identifies all appointment requests not meeting the timely access standards for behavioral health appointments with clear delineation of those resulting from member choice versus lack of appointment availability. (Herein 'Corrective Action Area No. 2'). [¶] c. Improved monitoring of member impact of access insufficiency and associated real time member remediation. This should demonstrate a clear policy and process ensuring that all members who are not offered timely access are reviewed for risk and ensured their needs are met. (Herein 'Corrective Action Area No. 3'). [¶] d. . . . [¶] e. Improved internal corrective action plan ('CAP') development. Internal CAPs to fully document the extent of root cause analysis and corrective action interventions. When a CAP does not result in timely improved results, there will be a process and associated documentation that demonstrates application of enhanced analysis, modification in CAP, and intensified effort. (Herein 'Corrective Action Area No. 5'). [¶] f. Improved integration of external

deliverables of benchmarks including, as relevant here, a date for "[i]mplementation of follow-up appointment monitoring process(es)." A provision of the agreement entitled "Limits of Consultation" provides, "This stipulated settlement agreement is intended to aid the Plan in further improving its Behavioral Health Quality Assurance program to ensure that effective action is taken to improve care where deficiencies are identified in service areas, including accessibility, availability, and continuity of care. This agreement is not intended to grant either the department or consultant the authority to regulate any relationship between the Plan and any other group or entity beyond the department's existing regulatory authority under the Knox-Keene Health Care Service Plan Act of 1975, as amended, Health and Safety Code section 1340, et seq., regulations promulgated thereunder ('Knox-Keene Act'), or any other state or federal law. The department does not intend to dictate clinical practice decisions of licensed providers."

At our request, the DMHC submitted an amicus brief addressing its role with respect to the issues raised by plaintiffs' claims. The DMHC's letter discusses both its settlement with Kaiser, as well as its "consumer complaint system, which handles consumer complaints and requests for independent medical review . . . of disputed health care services." According to the DMHC, the settlement was reached after the DMHC determined that Kaiser failed to perform "effective quality assurance monitoring of the availability of contracted mental health providers and timeliness of behavioral health appointments, and thus necessarily also failed to take adequate action in response to such monitoring. In essence, Kaiser had no viable way of measuring whether its members were getting appropriate behavioral health treatment." The letter continues, "[T]he Settlement Agreement addressed one specific problem related to behavioral health services at Kaiser—Kaiser's failure to adequately measure its members' ability to access

---

provider access data and oversight. External provider network will be fully integrated into the Plan's behavioral health access monitoring plan, processes, and reporting. The Plan shall ensure that a member's appointment access when referred to an external network complies with timely access standards found in Health and Safety Code section 1300.67.2.2. (Herein 'Corrective Action Area No. 6'. (Boldface omitted.)

behavioral health services. Such quality-assurance monitoring is a key part of any effort to ensure adequate access to behavioral health services: a plan cannot fix any problem that might exist regarding access to such services unless the plan first understands the nature and extent of the problem. Although this is a critical piece of the effort to ensure adequate access to behavioral health services, it is just one piece of that effort. The Settlement Agreement does not address other issues relevant to ensuring adequate access to behavioral and mental health services at Kaiser." The letter details the agency's consumer complaint and independent medical review processes but notes that "[a]lthough these processes could address issues beyond the scope of the Settlement Agreement (such as whether Kaiser contracted providers are not providing covered treatment or care to putative class members), they would necessarily do so solely on an individualized basis."[5]

[5] According to the DMHC, "These two administrative remedies—the consumer-complaint system and the [independent medical review] system—are effective mechanisms through which any individual class member could obtain resolution of a particularized complaint regarding a denial of health care services. . . . [¶] Although these administrative routes often provide effective relief to individual consumers, they are not intended to address broader, systemic concerns. To be sure, even individual complaints can help the DMHC address such systemic issues: patterns across such complaints can alert the DMHC to potentially systemic problems. At its core, however, the consumer-complaint and [independent medical review] systems necessarily revolve around individualized analyses of each particular complainant's specific grievance. The consumer-complaint and [independent medical review] systems are designed to provide relief to individuals, not to resolve whatever systemic issues might underlie their individual complaints. [¶] In the same vein, the DMHC's administrative mechanisms are also limited in the scope of their available remedies. Although these mechanisms allow reimbursement for out-of-pocket costs incurred for covered health care 14 services, they generally do not allow for other forms of money damages or restitution. Nor, consistent with their individualized nature, do they allow for declaratory or injunctive relief more complex than an order to cover a particular service in a particular case. [¶] . . . [¶] The DMHC's administrative processes are effective, but limited in scope; they supplement rather than supplant, whatever additional remedies might otherwise be appropriate under state law."

The court's finding that the DMHC is monitoring the Plan's provision of individual therapy for compliance with the requirements of the Parity Act is not supported. Plaintiffs' Parity Act claim does not turn on whether particular individuals or putative class members obtain timely appointments or on any defects in the Plan's quality assurance program. Rather, plaintiffs contend that the method by which the Plan requires appointments to be scheduled, together with available staff levels, preclude medically appropriate scheduling of individual therapy appointments. They argue that as a result of the Plan's common practices, the licensed providers do not and cannot make mental health treatment decisions based on their patients' individualized medical needs.[6]

c. Commonality

"The 'ultimate question' the element of predominance presents is whether 'the issues which may be jointly tried, when compared with those requiring separate adjudication, are so numerous or substantial that the maintenance of a class action would be advantageous to the judicial process and to the litigants.' [Citations.] The answer hinges on 'whether the theory of recovery advanced by the proponents of certification is, as an analytical matter, likely to prove amenable to class treatment.' [Citation.] A court must examine the allegations of the complaint and supporting declarations [citation] and consider whether the legal and factual issues they present are such that their resolution in a single class proceeding would be both desirable and feasible. 'As a general rule if the

[6] The trial court's discovery rulings help illustrate the difference between the issues scrutinized by the DMHC and the subject of plaintiffs' claim. In denying plaintiffs' requests for discovery into, among other things, "[the Plan's] efforts to assess or track the availability of behavioral appointments"; "average wait times that [Plan] members experience or have experienced between requesting a behavioral health appointment and actually receiving behavioral health treatment"; and "average wait times that [Plan] members experience or have experienced between new and return appointments for psychotherapy for the treatment of a behavioral health condition", the court observed that these lines of inquiry "improperly shift[] the focus away" from "the 'essence' or 'core allegations' of plaintiffs' complaint . . . that the treatment needs of plaintiffs and the putative class members were not based on a proper determination of medical necessity . . . and towards the area found by the court to be in the province of the DMHC."

defendant's liability can be determined by facts common to all members of the class, a class will be certified even if the members must individually prove their damages.' " (*Brinker Restaurant Corp. v. Superior Court, supra*, 53 Cal. 4th at pp. 1021-1022.)

In support of their motion for certification, plaintiffs presented evidence that their claims can be established with common proof and that individual factual determinations would not predominate. (See *Arce v. Kaiser Found. Health Plan, Inc*. (2010) 181 Cal.App.4th 471, 493 [common questions predominated on plaintiffs' UCL claims because plaintiff could prove a violation of the Parity Act "by showing that Kaiser categorically denies coverage for mental health care services that may, in some circumstances, be medically necessary, and that Kaiser does so without considering whether such services are in fact medically necessary for its individual plan members"].) Plaintiff presented deposition testimony showing that the Plan negotiates with the medical groups and provides the financial resources for the staff at each medical center. One witness explained that the Plan's motto, "Our Model - Care and Coverage Together," means that "we have an integrated model, and the hospital and the medical groups and the health plan work together to make sure that members get, as much as possible, all the care under one roof." The witness explained that the medical groups "get their budgets and they get their money from the health plan to provide services to [the Plan's] members."

Plaintiffs presented evidence that the Plan schedules patients in a manner that makes return or repeat appointments virtually impossible, and provides staff at levels that are insufficient to allow for frequent, individual therapy for patients who need it. For example, plaintiffs presented declarations from providers detailing how their availability for individual therapy is limited by the Plan's scheduling and staffing practices. The providers explained that in making treatment plans for patients, they are "severely limited by availability of therapy appointments and treatment modalities within Kaiser's integrated, closed system." One provider states, "Kaiser requires that I continue to regularly add new patients to my caseload at a rate of one or more per day. Once a patient is under my care, I am responsible for providing them all medically necessary one-on-one

therapy, and their-access to that treatment is limited by my availability. I currently am booked out approximately six to eight weeks for return therapy appointments, so my patients cannot receive one-on-one therapy more frequently than that. For many of my patients with Parity Act conditions, frequent one-on-one therapy is an essential part of the medically necessary care to treat their conditions. I have asked my manager to close my patient load so that I can have enough available appointments to provide therapy to my existing patients, but my requests have been denied or ignored." The provider continues, "Kaiser's system of treatment for mental disorders, including Parity Act diagnoses, is based on a model that emphasizes group therapy, with much more limited access to one-on-one therapy. My schedule is regulated by Kaiser consistent with this emphasis on group therapy. Because of the long waiting times for individual return visits, I sometimes refer patients to group therapy because that is the only available modality for them to receive any therapy at the frequency medically necessary to treat their condition. For some patients with Parity Act conditions, such as those that are actively suicidal or have psychosis, group therapy is not clinically appropriate and frequent one-on-one therapy is medically necessary to treat them." Another provider repeats the above testimony and adds that "while I have determined that some of my patients require weekly or frequent one-on-one therapy, this form of therapy is not in practice available within Kaiser's closed system given current staffing levels." Plaintiffs' evidence shows that once a patient is assigned to a particular provider, that clinician is responsible for providing all medically necessary one-on-one therapy to that patient. Kaiser has no written or consistent policy to ensure that patients receive care when their psychiatrists or therapists are on vacation. In addition, Kaiser's policy that "any patient that has received any contact with our department in the last two years is not considered a new patient" also poses a "barrier to patients receiving timely medically necessary treatment."

Plaintiffs also submitted survey data which shows that a significant number of providers believe their facility does not have sufficient staff to provide patients with timely return visits and evidence of patients who filed complaints reporting an inability to access individual therapy at all or with any regularity. Finally, plaintiffs presented

internal Kaiser documents showing that the Plan's staffing recommendations are inadequate to provide what Kaiser itself considers optimal patient outcomes.[7]

In opposition, the Plan argued that plaintiffs' evidence does not demonstrate a "common, classwide policy or practice . . . that resulted in plaintiffs or any putative class member . . . not obtaining medically necessary individual therapy." According to the Plan, "Whether a member obtained individual therapy in a particular instance turns on the provider's individual treatment decision and the individual circumstances of the particular case, making the claim not amenable to class treatment." The Plan argued that it "had no policy to deny, or effectively deny, coverage for return individual therapy." "Within Kaiser Permanente's integrated system, treating providers determine what services or treatments are medically necessary for their patients, based on their clinical judgment and experience, not on any Plan directive or guidance." "Specifically, if a clinician does not have sufficient available appointments to schedule individual therapy for certain patients, he or she can — and the evidence shows providers regularly did — convert blocks of time designated for other purposes, such as administrative work, to book return individual therapy appointments."

As demonstrated by the conflicting evidence, the dispute centers on the Plan's specified practices, not on the outcome of treatment to particular patients. While trial of the matter may elicit some evidence of individual cases, evidence of the manner in which patient scheduling is permitted, staffing is authorized, and statistical comparison of performance against recognized professional criteria would seem far more to the point.

The trial court found that plaintiffs had "not identified a common origin or cause of the common result on inadequate access to one-on-one therapy. In the absence of an identifiable common policy or practice that is the origin or cause of the alleged classwide result, common issues will not predominate at trial." But, as indicated above, plaintiffs' claim focusses precisely on the restrictions the Plan imposes on scheduling mental health

[7] Plaintiffs' request for judicial notice of a letter from the American Psychological Association and the California Psychological Association to the DMHC regarding Kaiser's access to mental health care is denied.

appointments and the pool of therapists that are available to provide the necessary treatment. Moreover, the court's analysis focuses on the Plan's formal policies rather than its actual practices. The court's order denying class certification explains, "In this case, the Kaiser Plan has a formal policy of covering mental health services. Plaintiffs assert that TPMG and SCPMG, as agents of the Kaiser plan, had an actual consistent practice of not covering [Parity Act] required services. In this case, the DMHC is charged with monitoring whether Kaiser Plan's actual practice is to deliver the treatment and care required by [the Parity Act]. Therefore, in defining claims for purposes of class certification the court will focus on the Kaiser Plan's formal policies regarding coverage and will be wary about permitting the claims to expand to include whether TPMG and SCPMG, as agents of the Kaiser Plan, had an actual and consistent practice of not providing covered treatment."

Based on the court's explanation of its decision, we are not confident that its predominance determination rests on proper considerations, and we may consider only those on which the trial court relied. (See *Bufil v. Dollar Financial Group, Inc.* (2008) 162 Cal.App.4th 1193, 1205 ["in our review of an order denying class certification, we consider only the reasons cited by the trial court for the denial, and ignore other reasons that might support denial"], disapproved on another ground by *Noel v. Thrifty Payless, Inc*. (2019) 7 Cal.5th 955, 986, fn. 15.) The court's apparent misunderstanding of the DMHC's limited role in scrutinizing systemic issues appears to have influenced its view of the class-wide issues requiring determination here. And "whether TPMG and SCPMG, as agents of the Kaiser Plan, had an actual and consistent practice of not providing covered treatment" is precisely the question central to plaintiffs' UCL claim. Whether that question can be answered by primary reliance on common proof or whether evidence specific to numerous individual patients necessarily will predominate is the issue that must now be determined, and its determination lies within the discretion of the trial court in the first instance. (*Ibid.*) Therefore, remand for reconsideration of the issue is required.

d. Superiority

In finding that class treatment is not the superior means of resolving plaintiffs' claims, the court's order states: "The availability of alternate procedures for handling the controversy depends on how the controversy is defined. Although plaintiffs nominally define the claim as Kaiser Plan's alleged systemwide failure to provide coverage that is required under the [Parity Act], the plaintiffs return repeatedly to argument and evidence that the Kaiser Plan's contracted providers . . . are systematically not actually providing covered treatment or care. [¶] . . . [¶] The claims in the Futterman case regarding one-on-one therapy are subject to DMHC oversight, and the DMHC has entered into a settlement agreement with the Kaiser Plan that is an effective means to handle those issues."

Because plaintiffs claim that the Plan is systematically limiting access to coverage for medically appropriate mental health treatment, not merely failing to measure and ensure timely access to prescribed treatment, their UCL cause of action is not addressed by the terms of the settlement agreement. Thus, the DMHC's oversight function is not an alternative, much less a superior, means of addressing the issues presented in plaintiffs' complaint, as the DMHC has itself acknowledged.

e. Conclusion

The grounds on which the court relied in denying certification are unsupported insofar as they rest on a misunderstanding of the scope of the DMHC's role with respect to plaintiffs' Parity Act claims and the precise issue to be determined. We shall therefore reverse the order denying certification of a Parity Act Class and remand the matter to ensure that the determination is made with a correct understanding of the claim for which class certification is requested. We stress that the evaluation of whether common issues preponderate is a matter within the sound discretion of the trial court. On remand the court will be in position to press counsel for the type of evidence and witnesses by which plaintiffs intend to prove their allegations, and by which defendants would seek to disprove them. After such detailed and specific showings, the trial court will be in the best position to make an informed determination as to whether proceeding on a class basis will or will not be manageable and more efficient and practical than the alternatives.

2. Unruh Act Subclass

The court denied certification of an Unruh Act subclass on the ground that common factual questions do not predominate. The court explained: "The Unruh Act claim concerns alleged violations affecting individual Kaiser Plan members in the past and seeks statutory damages on behalf of affected members. This would require the court to undertake an individualized review of the medical needs of the members of the proposed subclass." Plaintiffs contend that the court also misconstrued the systematic nature of this claim, asserting that the Unruh Act claim is based on the common question whether the Plan's systematic violation of the Parity Act establishes intentional discrimination based on a member's medical condition. They argue that because they seek only statutory damages under Civil Code section 52, subdivision (a),[8] as opposed to actual damages, there is no need for "the trial court to make any individualized or fact-intensive inquiry."

Proof of actual damages is not a prerequisite to recovery of statutory minimum damages under the Unruh Act. (*Hubbard v. Twin Oaks Health & Rehab. Ctr.* (E.D.Cal. 2004) 408 F.Supp.2d 923.) Nonetheless, each class member must establish his or her standing to recover the statutory penalty. " '[A]n individual plaintiff has standing under the [Unruh Civil Rights] Act if he or she has been the victim of the defendant's discriminatory act.' [Citation.] . . . 'The focus of the standing inquiry is on the plaintiff, not on the issues he or she seeks to have determined; he or she must have a special interest that is greater than the interest of the public at large and that is concrete and actual rather than conjectural or hypothetical.' " (*Osborne v. Yasmeh* (2016) 1 Cal.App.5th 1118, 1127, quoting *Angelucci v. Century Supper Club* (2007) 41 Cal.4th 160, 175.) To establish standing in this case, each class member would be required to

[8] Civil Code section 52, subdivision (a) provides that anyone who violates the Act "is liable for each and every offense for the actual damages, and any amount that may be determined by a jury, or a court sitting without a jury, up to a maximum of three times the amount of actual damage but in no case less than four thousand dollars ($4,000), and any attorney's fees that may be determined by the court in addition thereto . . . ."

establish that he or she was injured by the Plan's restrictive practices. A Kaiser member who did not need more extensive or one-on-one therapy would not have been injured by any failure to have provided more extensive treatment. Determining standing would, as the trial court observed, "require the court to undertake an individualized review of the medical needs of the members of the proposed subclass for the proposed subclass period." Therefore, the trial court did not err in denying certification of the Unruh Act class. (See *Bartlett v. Hawaiian Village, Inc.* (1978) 87 Cal.App.3d 435, 438–439 & fn. 6 [upholding denial of class certification in an action under the Unruh Act for alleged discrimination in admitting patrons to a bath house because individual issues, including whether each class member had requested and been denied admission predominated].)

Disposition

The order denying class certification is reversed with respect to the proposed Parity Act Class and affirmed with respect to the proposed Unruh Act subclass. The matter is remanded for further proceedings on plaintiffs' motion to certify a Parity Act Class. The parties shall bear their respective costs on appeal.

POLLAK, P. J.

WE CONCUR:

STREETER, J.
BROWN, J.